		FOR OHF USE					

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2001
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2001)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0025023

Facility Name: Lutheran Care Center

Address: 702 West Cumberland (Number) Altamont (City) 62411 (Zip Code)

County: Effingham

Telephone Number: (618) 483-6136 **Fax #** (618) 483-5607

IDPA ID Number: 371072628001

Date of Initial License for Current Owners: 10/01/80

Type of Ownership:

x	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL		
	x	Charitable Corp.		Individual		State	
		Trust		Partnership		County	
IRS Exemption Code	501(c)(3)			Corporation		Other	
				"Sub-S" Corp.			
				Limited Liability Co.			
				Trust			
				Other			

In the event there are further questions about this report, please contact:
Name: Charles J. Fischer **Telephone Number:** (312) 634-3400
Please send copies of desk review and audit adjustments to address on this page

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 10/1/00 to 9/30/01 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) _____
(Title) _____

Paid Preparer
(Signed) SEE ACCOUNTANTS' COMPILATION REPORT (Date)
(Print Name and Title) _____
(Firm Name & Address) Altschuler, Melvoin and Glasser LLP, One South Wacker Drive, Suite 800, Chicago, IL 60606
(Telephone) (312) 634-3400 Fax # (312) 634-5518

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lutheran Care Center # 0025023 Report Period Beginning: 10/1/00 Ending: 9/30/01

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	96	Skilled (SNF)	96	35,040	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	96	TOTALS	96	35,040	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	3,126	6,015	1,115	10,256	8
9	SNF/PED					9
10	ICF	10,158	9,759		19,917	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	13,284	15,774	1,115	30,173	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 86.11%

D. How many bed-hold days during this year were paid by Public Aid?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [x] NO [ ] Non-allowable costs have been eliminated in Schedule V, Column 7

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [x] NO [ ]

I. On what date did you start providing long term care at this location?
Date started 10/01/80

J. Was the facility purchased or leased after January 1, 1978?
YES [x] Date 10/01/80 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [x] NO [ ] If YES, enter number of beds certified 6 and days of care provided 1,115

Medicare Intermediary Mutual of Omaha Insurance Company

IV. ACCOUNTING BASIS

ACCRUAL [x] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [x] NO [ ]

Tax Year: 9/30/01 Fiscal Year: 9/30/01

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lutheran Care Center # 0025023 Report Period Beginning: 10/1/00 Ending: 9/30/01

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7**	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	228,182	19,823	6,671	254,676		254,676		254,676			1
2	Food Purchase		147,842		147,842		147,842	(4,462)	143,380			2
3	Housekeeping	83,053	13,628		96,681		96,681		96,681			3
4	Laundry	68,385	13,878	402	82,665		82,665		82,665			4
5	Heat and Other Utilities			82,987	82,987		82,987		82,987			5
6	Maintenance	31,294	1,826	21,366	54,486		54,486		54,486			6
7	Other (specify):*											7
8	**TOTAL General Services**	410,914	196,997	111,426	719,337		719,337	(4,462)	714,875			8
	B. Health Care and Programs											
9	Medical Director			400	400		400		400			9
10	Nursing and Medical Records	1,059,967	70,235	2,588	1,132,790		1,132,790		1,132,790			10
10a	Therapy	118,965	238	7,934	127,137		127,137		127,137			10a
11	Activities	39,808	2,229	2,390	44,427		44,427		44,427			11
12	Social Services	39,689	258	537	40,484		40,484		40,484			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,258,429	72,960	13,849	1,345,238		1,345,238		1,345,238			16
	C. General Administration											
17	Administrative	48,187			48,187		48,187		48,187			17
18	Directors Fees											18
19	Professional Services			41,259	41,259		41,259		41,259			19
20	Dues, Fees, Subscriptions & Promotions			8,688	8,688		8,688	(75)	8,613			20
21	Clerical & General Office Expenses	88,899	4,876	25,941	119,716		119,716	(1,451)	118,265			21
22	Employee Benefits & Payroll Taxes			390,742	390,742		390,742		390,742			22
23	Inservice Training & Education											23
24	Travel and Seminar			4,141	4,141		4,141		4,141			24
25	Other Admin. Staff Transportation			2,317	2,317		2,317		2,317			25
26	Insurance-Prop.Liab.Malpractice			49,901	49,901		49,901		49,901			26
27	Other (specify):*											27
28	**TOTAL General Administration**	137,086	4,876	522,989	664,951		664,951	(1,526)	663,425			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,806,429	274,833	648,264	2,729,526		2,729,526	(5,988)	2,723,538			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Lutheran Care Center #0025023 Report Period Beginning: 10/1/00 Ending: 9/30/01

V. COST CENTER EXPENSES (continued)

		Cost Per General Ledger				Reclass-	Reclassified	Adjust-	Adjusted	FOR OHF USE ONLY		
	Capital Expense	Salary/Wage	Supplies	Other	Total	ification	Total	ments	Total			
	D. Ownership	1	2	3	4	5	6	7**	8	9	10	
30	Depreciation			98,817	98,817		98,817	(2,357)	96,460			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			15,567	15,567		15,567	(10,037)	5,530			32
33	Real Estate Taxes			170	170		170	(170)				33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			1,199	1,199		1,199		1,199			35
36	Other (specify):*											36
37	**TOTAL Ownership**			115,753	115,753		115,753	(12,564)	103,189			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		17,576	2,904	20,480		20,480		20,480			39
40	Barber and Beauty Shops			14,607	14,607		14,607		14,607			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			52,560	52,560		52,560		52,560			42
43	Other (specify):* Nonallowable costs	107,523	37,984	249,955	395,462		395,462	(395,462)				43
44	**TOTAL Special Cost Centers**	107,523	55,560	320,026	483,109		483,109	(395,462)	87,647			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,913,952	330,393	1,084,043	3,328,388		3,328,388	(414,014)	2,914,374			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

****See schedule of adjustments attached at end of cost report**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lutheran Care Center # 0025023 Report Period Beginning: 10/1/00 Ending: 9/30/01

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(4,299)	2		4
5	Telephone, TV & Radio in Resident Rooms	(1,235)	43		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(2,357)	30		9
10	Interest and Other Investment Income	(10,037)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)	(2,553)	43		16
17	Non-Care Related Fees	(170)	33		17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(27,494)	43		24
25	Fund Raising, Advertising and Promotional	(12,965)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Schedule 5A	(352,904)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (414,014)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (414,014)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

SEE ACCOUNTANTS' COMPILATION REPORT

Lutheran Care Center

ID# 0025023

Report Period Beginning: 10/1/00

Ending: 9/30/01

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1		$		1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	0		49

STATE OF ILLINOIS — Summary A

Facility Name & ID Number Lutheran Care Center # 0025023 **Report Period Beginning:** 10/1/00 **Ending:** 9/30/01

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(4,299)	0	0	0	0	0	0	0	0	0	0	(4,299)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(4,299)	0	0	0	0	0	0	0	0	0	0	(4,299)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	0	0	0	0	0	0	0	0	0	0	0	0	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(4,299)	0	0	0	0	0	0	0	0	0	0	(4,299)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Lutheran Care Center # 0025023 **Report Period Beginning:** 10/1/00 **Ending:** 9/30/01

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
30	Depreciation	(2,357)	0	0	0	0	0	0	0	0	0	0	(2,357)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(10,037)	0	0	0	0	0	0	0	0	0	0	(10,037)	32
33	Real Estate Taxes	(170)	0	0	0	0	0	0	0	0	0	0	(170)	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(12,564)	0	0	0	0	0	0	0	0	0	0	(12,564)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(44,247)	0	0	0	0	0	0	0	0	0	0	(44,247)	43
44	**TOTAL Special Cost Centers**	(44,247)	0	0	0	0	0	0	0	0	0	0	(44,247)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(61,110)	0	0	0	0	0	0	0	0	0	0	(61,110)	45

Lutheran Care Center
Provider # - 0025023
Fiscal Year End - 9/30/01 **Schedule 5A**

VI. Adjustment Detail

Other Non-Allowable Expenses	Amount	Reference
Miscellaneous Expense Offset	(1,451)	21
Offset Vending Machine Income	(163)	2
Non-allowable Dues and Subscriptions	(75)	20
Luther Villas Salaries and Wages	(2,265)	43
Luther Villas Supplies Expense	(12,752)	43
Luther Villas Other Expense	(31,440)	43
Luther Terrace Salaries & Wages Expense	(105,258)	43
Luther Terrace Supplies Expense	(25,232)	43
Luther Terrace Other Expense	(174,268)	43
Total	$ (352,904)	

See Accountants' Compilation Report

Facility Name & ID Number Lutheran Care Center # 0025023 Report Period Beginning: 10/1/00 Ending: 9/30/01

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
		N/A				

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [ ] YES [x] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V			$			$	$	1
2	V								2
3	V								3
4	V				N/A				4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$			$	$ *	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lutheran Care Center # 0025023 Report Period Beginning: 10/1/00 Ending: 9/30/01

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									$		1
2											2
3											3
4		See attached schedule for Board of Directors									4
5		Note: No members of the Board provided services to the nursing home									5
6		Note: No members of the Board owned businesses that provided services to the nursing home									6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Lutheran Care Center # 0025023 Report Period Beginning: 10/1/00 Ending: 9/30/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [x]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5				N/A						5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lutheran Care Center # 0025023 Report Period Beginning: 10/1/00 Ending: 9/30/01

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	First Mid-Illinois Bank & Trust		x	Purchase of new roof	$2,246.00	6/23/97	$ 177,000	$	8/23/03	0.0900	$ 7,454	1
2												2
3												3
4												4
5												5
	Working Capital											
6	First Mid-Illinois Bank & Trust		x	Working capital		6/13/97	75,000	55,000	7/19/02	P+.0100	2,579	6
7												7
8												8
9	TOTAL Facility Related				$2,246.00		$ 252,000	$ 55,000			$ 10,033	9
	B. Non-Facility Related*											
10	First Mid-Illinois Bank & Trust		x	Luther Terrace mortgage		6/16/97	1,000,000	944,080	6/15/27	0.0720	73,996	10
11								Interest Income Offset			(10,037)	11
12								Non-Care Related Interest			(68,462)	12
13												13
14	TOTAL Non-Facility Related						$ 1,000,000	$ 944,080			$ (4,503)	14
15	TOTALS (line 9+line14)						$ 1,252,000	$ 999,080			$ 5,530	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Lutheran Care Center # 0025023 Report Period Beginning: 10/1/00 Ending: 9/30/01

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2000 report. *Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	2
3. Under or (over) accrual (line 2 minus line 1).	$	3
4. Real Estate Tax accrual used for 2001 report. (Detail and explain your calculation of this accrual on the lines below.)	$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	N/A $	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For 19 Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
	1996	8
	1997	9
	1998	10
	1999	11
	2000	12

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2000	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, [illegible]

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Lutheran Care Center COUNTY Effingham

FACILITY IDPH LICENSE NUMBER 0025023

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE ( ) FAX #: ( )

A. **Summary of Real Estate Tax Cos**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of tl cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursir home property which is vacant, rented to other organizations, or used for purposes other than long term care must not l entered in Column D. Do not include cost for any period other than calendar year 200(

	(A) Tax Index Numbe	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not direct used for nursing home services? _____ YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing hom (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used

C. **Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill whic is normally paid during 2001.

Facility Name & ID Number Lutheran Care Center # 0025023 Report Period Beginning: 10/1/00 Ending: 9/30/01

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 25,884 B. General Construction Type: Exterior Brick Frame Steel Number of Stories 1

C. Does the Operating Entity? [x] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.

D. Does the Operating Entity? [x] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [x] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable)

Luther Villas - Independent Living 7 units -7,700 square feet

Luther Terrace - Independent Living 16 units - 13, 688 square feet

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [x] NO
If so, please complete the following:

1. Total Amount Incurred: N/A
2. Number of Years Over Which it is Being Amortized: N/A
3. Current Period Amortization: N/A
4. Dates Incurred: N/A

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Resident Care	239,085	1980	$ 35,000	1
2	Resident Care	197,415	1987	28,900	2
3	TOTALS	436,500		$ 63,900	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lutheran Care Center # 0025023 Report Period Beginning: 10/1/00 Ending: 9/30/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	96		1980	1969	$ 867,500	$ 34,700	25	$ 34,700	$	$ 728,700	4
5			1980	1969	12,000	480	25	480		10,080	5
6			1980	1974	141,000	5,640	25	5,640		118,440	6
7			1980	1969	10,000		25	400	400	8,600	7
8			1980	1977	1,000		25	40	40	860	8
	Improvement Type**										
9	Therapy Room			1981	3,764	151	25	151		3,036	9
10	Land Improvements			1980	28,500	1,210	25	1,140	(70)	25,322	10
11	Land Improvements			1986	2,000	80	25	80		1,166	11
12	Land Improvements			1987	2,143	86	25	86		1,264	12
13	Land Improvements			1991	491	20	25	20		275	13
14	Building Improvements			1981	3,486		5			3,486	14
15	Building Improvements			1982	6,557	327	20	327		6,420	15
16	Building Improvements			1982	163		10			163	16
17	Building Improvements			1985	940		10			940	17
18	Building Improvements			1985	2,512	126	20	126		2,018	18
19	Building Improvements			1986	955		10			955	19
20	Building Improvements			1986	1,949	97	20	97		1,536	20
21	Building Improvements			1987	2,150		10			2,150	21
22	Building Improvements			1987	1,023	51	20	51		724	22
23	Building Improvements			1988	1,500		10			1,500	23
24	Building Improvements			1989	16,021		10			16,021	24
25	Building Improvements			1989	241	16	15	16		197	25
26	Building Improvements			1989	14,979		20			14,979	26
27	Building Improvements			1990	6,315		5			6,315	27
28	Building Improvements			1990	20,381		10			20,381	28
29	Building Improvements			1990	10,176	678	15	678		7,632	29
30	Building Improvements			1990	1,656	83	20	83		931	30
31	Building Improvements			1991	6,000	450	10	450		6,000	31
32	Building Improvements			1992	7,122		7			7,122	32
33	Building Improvements			1992	4,345	435	10	435		4,019	33
34	Misc Flooring/ Wallpaper			1993	3,762		5			3,762	34
35											35
36											36

*Total beds on this schedule must agree with page 2.

See Page 12A, Line 70 for total

**Improvement type must be detailed in order for the cost report to be considered complete

Facility Name & ID Number Lutheran Care Center # 0025023 Report Period Beginning: 10/1/00 Ending: 9/30/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Dining Room	1993	$ 82,632	$ 2,623	31.5	$ 2,623	$	$ 20,658	37
38	Sprinkler System	1994	31,932	798	40	798		5,760	38
39	Additional Patio Work	1994	1,725	43	40	43		308	39
40	Dining Room Floor	1994	2,788	70	40	70		501	40
41	Breakroom Wallpaper	1994	302	8	40	8		57	41
42	Admin Office Wallpaper	1994	381	10	40	10		70	42
43	Lobby Wall Covering	1994	2,759	69	40	69		495	43
44	Floor Tile	1994	683	17	40	17		122	44
45	Misc. Bldg. Improvements	1994	1,408	35	40	35		251	45
46	Land Imp. - Sewer Line	1994	7,949	199	40	199		1,442	46
47	Land Imp. - Drainage Pipe	1994	860	21	40	21		153	47
48	Misc. Land Improvements	1994	1,279	32	40	32		232	48
49	Building Improvements	1995	7,804	200	40	200		1,287	49
50	Carpet for Lobby	1995	1,465	146	10	146		806	50
51	Office Wallpaper	1995	622	62	10	62		342	51
52	Front Office Wallpaper	1995	825	82	10	82		454	52
53	Activity Office Counter Top	1995	1,575	157	10	157		866	53
54	Flooring North Hall	1996	717	72	10	72		394	54
55	Air Conditioner Unit	1996	8,400	840	10	840		4,620	55
56	Air Conditioner Unit	1996	940	94	10	94		517	56
57	Air Conditioner Unit	1996	560	56	10	56		308	57
58	Gas Line	1996	947	95	10	95		520	58
59	Flooring Halls	1995	1,822	182	10	182		956	59
60	Flooring Halls	1994	1,267	127	10	127		666	60
61	Fire Alarm System	1996	2,429	243	10	243		1,336	61
62	Building Improvements	1996	697	70	10	70		383	62
63	Parking lot improvements	1997	1,500	75	20	75		338	63
64	Parking lot improvements	1997	2,510	251	10	251		1,130	64
65	Electrical wiring	1997	1,171	117	10	117		527	65
66	5 ton air conditioner unit	1997	5,330	533	10	533		2,399	66
67	Front entrance awning	1997	2,867	287	10	287		1,290	67
68	Electrical wiring	1997	966	97	10	97		435	68
69									69
70	TOTAL (lines 4 thru 69)		$ 1,359,743	$ 52,341		$ 52,711	$ 370	$ 1,054,617	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete

Facility Name & ID Number Lutheran Care Center # 0025023 Report Period Beginning: 10/1/00 Ending: 9/30/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 1,359,743	$ 52,341		$ 52,711	$ 370	$ 1,054,617	1
2	New administrative offices	1997	77,471		40	2,905	2,905		2
3	Dietary refrigeration system	1997	18,095	2,431	10	1,810	(621)	8,468	3
4	Cabinets & counter tops	1997	11,664	1,166	10	1,166		5,249	4
5	Roof	1998	178,417	8,921	20	8,921		31,223	5
6	Dry wall, blinds, flooring, paint, closets (Remodeling-Medicare Rooms	1998	2,445	122	20	122		428	6
7	Plumbing, blinds, lighting (Remodeling - Medicare Rooms	1998	384	122	10	38	(84)	343	7
8	Plumbing, paint, lumber (Remodeling-Medicare Room	1998	834	472	10	83	(389)	291	8
9	Plumbing, carpeting, blinds, lumber (Remodeling-Medicare Room	1998	3,548	694	10	355	(339)	1,243	9
10	Plumbing, shelving, paint, draperies, cabinets, wall coverings (Medicare R	1998	2,576	354	10	258	(96)	1,144	10
11	Parking lot improvements	1998	1,298	130	10	130		454	11
12									12
13	Building Improvements - per 1994 audit	1981	1,140		10			1,140	13
14	Building Improvements - per 1994 audit	1982	2,159		10			2,159	14
15	Building Improvements - per 1994 audit	1984	1,677		10			1,677	15
16									16
17	Landscaping	1999	4,080	204	20	204		510	17
18	Electrical, lighting (Remodeling -Medicare Rooms)	1999	295	30	10	30		74	18
19	Dry wall (Remodeling-Medicare Rooms)	1999	196	20	10	20		49	19
20	Closets (Remodeling-Medicare Rooms)	1999	1,474	211	10	211		527	20
21	Phone jacks, shelving, paint (Remodeling-Medicare Rooms	1999	652	65	10	65		163	21
22	Cove base (Medicare room remodeling)	1999	77	8	10	8		19	22
23	Plumbing, gas line (Laundry Expansion	1999	3,156	158	20	158		394	23
24	Concrete, roof, lumber, building materials (Laundry Expansion	1999	7,063	353	20	353		883	24
25	Brick work (Laundry Expansion)	1999	4,553	227	20	227		569	25
26	Concrete, roof, gas line, building materials (Laundry Expansion	1999	2,708	135	20	135		338	26
27	Air Conditioner Improvements	1999	677	135	5	135		339	27
28	Wallcoverings, hand rails, chair rails (Remodeling - Medicare Rooms)	2000	1,684	168	10	168		252	28
29	Drywall, wall coverings, paint (Remodeling - Medicare Rooms)	2000	2,056	206	10	206		308	29
30	Hardware supplies (Remodeling - Medicare Rooms)	2000	59	6	10	6		9	30
31	Wallcoverings, draperies, chair rails (Remodeling - Medicare Rooms)	2000	8,853	915	10	885	(30)	1,343	31
32	Wallcovering (Remodeling - Medicare Rooms)	2000	59	6	10	6		9	32
33									33
34	TOTAL (lines 1 thru 33)		$ 1,699,093	$ 69,600		$ 71,316	$ 1,716	$ 1,114,222	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete

Facility Name & ID Number Lutheran Care Center # 0025023 Report Period Beginning: 10/1/00 Ending: 9/30/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 1,699,093	$ 69,600		$ 71,316	$ 1,716	$ 1,114,222	1
2									2
3	Sidewalk	2000	2,300		20	115	115	173	3
4									4
5	Miscellaneous depreciation difference			4,082			(4,082)		5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 1,701,393	$ 73,682		$ 71,431	$ (2,251)	$ 1,114,395	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete

Facility Name & ID Number Lutheran Care Center # 0025023 Report Period Beginning: 10/1/00 Ending: 9/30/01

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 124,278	$ 18,492	$ 18,386	$ (106)	5-7 Yrs	$ 104,544	71
72	Current Year Purchases	22,883	2,288	2,288		5-7 Yrs	2,288	72
73	Fully Depreciated Assets	378,880				5-7 Yrs	378,880	73
74								74
75	TOTALS	$ 526,041	$ 20,780	$ 20,674	$ (106)		$ 485,712	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Facility Use	2001 Dodge E250 Van	2001	$ 39,825	$ 3,798	$ 3,798	$	5	$ 3,798	76
77	Facility Use	1990 Oldsmobile Wagon	2001	3,340	557	557		3	557	77
78										78
79										79
80	TOTALS			$ 43,165	$ 4,355	$ 4,355	$		$ 4,355	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 2,334,499	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 98,817	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 96,460	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (2,357)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,604,462	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	Net Fixed Assets	$	$	$	86
87	Luther Villas & Luther Terrace	1,442,898	47,527	232,974	87
88					88
89					89
90					90
91	TOTALS	$ 1,442,898	$ 47,527	$ 232,974	91

G. Construction-in-Progress

	Description	Cost	
92	Chapel	$ 30,078	92
93			93
94			94
95		$ 30,078	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Lutheran Care Center # 0025023 Report Period Beginning: 10/1/00 Ending: 9/30/01

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions				N/A			4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34. This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2002	$
13.	/2003	$
14.	/2004	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ 1,199 Description: Dishwaser - $1,199
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18			N/A		18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lutheran Care Center # 0025023 Report Period Beginning: 10/1/00 Ending: 9/30/01

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [ ] YES [X] NO

It is the policy of this facility to only hire certified nurses aides

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lutheran Care Center # 0025023 Report Period Beginning: 10/1/00 Ending: 9/30/01

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	L10a, C1,2	247 hrs	$ 3,718		$	$ 67	247	$ 3,785	1
2	Licensed Speech and Language Development Therapist	L10a, C3	hrs		113	7,631		113	7,631	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	L10a, C1,2	7683 hrs	115,247	4	303	171	7,687	115,721	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	L39, C2	# of prescrpts				17,576		17,576	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): Laboratory	L39, C3				2,904			2,904	13
14	TOTAL			$ 118,965	117	$ 10,838	$ 17,814	8,047	$ 147,617	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lutheran Care Center # 0025023 Report Period Beginning: 10/1/00 Ending: 9/30/01

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 9/30/01 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 760,791	$ 760,791	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 10,000)	401,508	401,508	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	34,125	34,125	6
7	Other Prepaid Expenses	18,269	18,269	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,214,693	$ 1,214,693	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	63,710	63,900	13
14	Buildings, at Historical Cost	1,641,149	1,701,393	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	559,035	569,206	16
17	Accumulated Depreciation (book methods)	(1,567,631)	(1,604,462)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (sp Mortgage Costs	7,360	7,360	22
23	Other(specify): Net F/A - Villas & Terrace	1,312,070	1,240,002	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 2,015,693	$ 1,977,399	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 3,230,386	$ 3,192,092	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 47,650	$ 47,650	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	3,854	3,854	28
29	Short-Term Notes Payable	55,000	55,000	29
30	Accrued Salaries Payable	153,354	153,354	30
31	Accrued Taxes Payable (excluding real estate taxes)	2,958	2,958	31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	2,915	2,915	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Employee Withholdings	2,129	2,129	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 267,860	$ 267,860	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	944,080	944,080	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Deferred Rent	85,160	85,160	43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 1,029,240	$ 1,029,240	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,297,100	$ 1,297,100	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,933,286	$ 1,894,992	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 3,230,386	$ 3,192,092	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Facility Name & ID Number Lutheran Care Center # 0025023 Report Period Beginning: 10/1/00 Ending: 9/30/01

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,233,892	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,233,892	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	699,394	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 699,394	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 1,933,286	24 *

Operating entity only

*** This must agree with page 17, line 47.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lutheran Care Center # 0025023 Report Period Beginning: 10/1/00 Ending: 9/30/01

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 2,531,126	1
2	Discounts and Allowances for all Levels	99,540	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,630,666	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	149,070	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 149,070	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	14,108	13
14	Non-Patient Meals	8,006	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	26,537	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	19,059	19
20	Radiology and X-Ray		20
21	Other Medical Services	67,063	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 134,773	23
	D. Non-Operating Revenue		
24	Contributions	737,004	24
25	Interest and Other Investment Income***	15,961	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 752,965	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Rental of Independent Living Units	358,672	28
28a	See Schedule 19A	1,636	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 360,308	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 4,027,782	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	719,337	31
32	Health Care	1,345,238	32
33	General Administration	664,951	33
	B. Capital Expense		
34	Ownership	115,753	34
	C. Ancillary Expense		
35	Special Cost Centers	430,549	35
36	Provider Participation Fee	52,560	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 3,328,388	40
41	**Income before Income Taxes (line 30 minus line 40)****	699,394	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 699,394	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? Yes If not, please attach a reconciliation. Lutheran Care Center is a Not-For-Profit entity.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation. SEE ACCOUNTANTS' COMPILATION REPORT**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Lutheran Care Center
Provider # - 0025023
Fiscal Year End - 9/30/01

Schedule 19A

XVII E. Other Revenues

Line 28a:

Gain on Sale of Fixed Assets	$ 3,000
Dietary Fund Income	5,344
Activity Fund Income	1,636
Finance Charge Income	3,387
Personal Purchase Income	3,332
Vending Machine Income	163
Interest Income - Luther Villas	687
Telephone Income - Luther Terrace	1,381
Miscellaneous Income	1,451
Miscellaneous Income - Luther Terrace	857
Total	$ 21,238

See Accountants' Compilation Report

Facility Name & ID Number Lutheran Care Center # 0025023 Report Period Beginning: 10/1/00 Ending: 9/30/01

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,906	2,090	$ 37,885	$ 18.13	1
2	Assistant Director of Nursing	1,904	2,105	32,218	15.31	2
3	Registered Nurses	5,698	6,153	97,121	15.78	3
4	Licensed Practical Nurses	19,558	21,342	256,155	12.00	4
5	Nurse Aides & Orderlies	63,879	68,592	559,572	8.16	5
6	Nurse Aide Trainees					6
7	Licensed Therapist	4,244	4,586	83,987	18.31	7
8	Rehab/Therapy Aides	3,887	4,259	34,978	8.21	8
9	Activity Director	1,953	2,163	21,848	10.10	9
10	Activity Assistants	2,350	2,429	17,960	7.39	10
11	Social Service Workers	3,283	3,527	39,689	11.25	11
12	Dietician					12
13	Food Service Supervisor	1,873	2,076	24,262	11.69	13
14	Head Cook	1,856	2,089	19,956	9.55	14
15	Cook Helpers/Assistants	30,105	33,454	183,964	5.50	15
16	Dishwashers					16
17	Maintenance Workers	3,634	4,030	31,294	7.77	17
18	Housekeepers	13,762	14,965	83,053	5.55	18
19	Laundry	8,418	9,135	68,385	7.49	19
20	Administrator	1,880	2,115	48,187	22.78	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,953	2,134	29,188	13.68	23
24	Clerical	5,514	6,075	59,711	9.83	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Ca See Sch 20A	5,693	6,309	77,016	12.21	32
33	Other(specify) See Sch 20A	12,580	13,674	107,523	7.86	33
34	TOTAL (lines 1 - 33)	195,930	213,302	$ 1,913,952 *	$ 8.97	34

SEE ACCOUNTANTS' COMPILATION REPORT

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	126	$ 5,471	L1, C3	35
36	Medical Director	30	400	L9, C3	36
37	Medical Records Consultant	24	1,470	L10, C3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	120	540	L10, C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	10	537	L11, C3	44
45	Social Service Consultant	10	537	L12, C3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	320	$ 8,955		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Nurse Aides	16	279	L10, C3	52
53	TOTAL (lines 50 - 52)	16	$ 279		53

Lutheran Care Center
Provider # - 0025023
Fiscal Year End - 9/30/01

Schedule 20A

XVIII. A. Staffing and Salary Costs

Line 32 Other Health Care:

	# of Hours Worked	# of Hours Paid	Total Salaries/Wages	Avg. Hourly Wage
Care Plan Nurse	1,913	2,127	$ 30,347	14.27
Quality Assurance Coordinato	1,907	2,133	$ 30,575	14.33
Ward Clerk	1,873	2,049	$ 16,094	7.85
Total	5,693	6,309	77,016	12.21

Line 33 Other:

	# of Hours Worked	# of Hours Paid	Total Salaries/Wages	Avg. Hourly Wage
Independent Living Wages	12,580	13,674	$ 107,523	7.86
Total	12,580	13,674	107,523	7.86

See Accountants' Compilation Report

Facility Name & ID Number Lutheran Care Center # 0025023 Report Period Beginning: 10/1/00 Ending: 9/30/01

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Karen Hille	Administrator	0%	$ 48,187
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 48,187

B. Administrative - Other

Description	Amount
	$
N/A	
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
ADP	Payroll Services	$ 13,800
Altschuler, Melvoin &	Accounting	17,993
Glasser, LLP		
American Express Tax &	Accounting	2,065
Business Services		
Achieve	Computer Maintenance	7,131
Taylor Law Offices	Legal	270
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 41,259

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 71,265
Unemployment Compensation Insurance	
FICA Taxes	132,380
Employee Health Insurance	172,218
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Physicals	1,160
Employee Uniform Expense	130
Life Insurance	2,395
Other Employee Benefits	11,194
TOTAL (agree to Schedule V, line 22, col.8)	$ 390,742

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
N/A		
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	1,561
Health Care Worker Background Check	480
(Indicate # of checks performed 40)	
Life Services Network Dues	2,592
Various Licenses	1,322
Various Fees	1,167
Various Dues, Fees, Subscriptions	1,491
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 8,613

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	697
See Attached Detail	
Seminar Expense	3,444
See Attached Detail	
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 4,141

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lutheran Care Center # 0025023 Report Period Beginning: 10/1/00 Ending: 9/30/01

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5							N/A						
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Lutheran Care Center # 0025023 **Report Period Beginning:** 10/1/00 **Ending:** 9/30/01

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **Life Services Network of Illinois - $2,592**

(3) Did the nursing home make political contributions or payments to a politica
action organization? **No** If YES, have these costs
been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the
end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **7.5 Years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense
and the location of this expense on Sch. V. $ **24,701** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures
consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? ____ YES **x** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for
Schedule VII)? YES ____ NO **x** If YES, please indicate name of the facility,
IDPH license number of this related party and the date the present owners took over
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department
of Public Aid during this cost report period. $ **52,560**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V
for an individual employee? **No** If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

(13) Have costs for all supplies and services which are of the type that can be billed to
the Department of Public Aid, in addition to the daily rate, been properly classified
in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for
the patient census listed on page 2, Section B? **No** For example,
is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach
a schedule which explains how all related costs were allocated to these functions

(15) Indicate the cost of employee meals that has been reclassified to employee benefits
on Schedule V. $ **0** Has any meal income been offset against
related costs? **Yes** Indicate the amount. $ **4,299**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for
residents? **No** If YES, please indicate the amount of income earned from such a
program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **0**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other
times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted
out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such
transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **Altschuler, Melvoin & Glasser, LLP** The instructions for the
cost report require that a copy of this audit be included with the cost report. Has this copy
been attached? **Yes** If no, please explain. **N/A**

(18) Have all costs which do not relate to the provision of long term care been adjusted ou
out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services
performed been attached to this cost report? **N/A**
Attach invoices and a summary of services for all architect and appraisal fees.

	Salaries	Supplies	Other	Total	Reclass-ifications	Reclassified Total	Adjustmen	Adjusted Total
1. Dietary	228,182	19,823	6,671	254,676	0	254,676	0	254,676
2. Food P	0	147,842	0	147,842	0	147,842	-4,462	143,380
3. Housek	83,053	13,628	0	96,681	0	96,681	0	96,681
4. Laundry	68,385	13,878	402	82,665	0	82,665	0	82,665
5. Heat ar	0	0	82,987	82,987	0	82,987	0	82,987
6. Mainter	31,294	1,826	21,366	54,486	0	54,486	0	54,486
7. Other (s	0	0	0	0	0	0	0	0
8. Total G	410,914	196,997	111,426	719,337	0	719,337	-4,462	714,875
9. Medical	0	0	400	400	0	400	0	400
10. Nursin	1,059,967	70,235	2,588	1,132,790	0	1,132,790	0	1,132,790
10a. Ther	118,965	238	7,934	127,137	0	127,137	0	127,137
11. Activit	39,808	2,229	2,390	44,427	0	44,427	0	44,427
12. Social	39,689	258	537	40,484	0	40,484	0	40,484
13. Nurse	0	0	0	0	0	0	0	0
14. Progra	0	0	0	0	0	0	0	0
15. Other	0	0	0	0	0	0	0	0
16. Total H	1,258,429	72,960	13,849	1,345,238	0	1,345,238	0	1,345,238
17. Admin	48,187	0	0	48,187	0	48,187	0	48,187
18. Direct	0	0	0	0	0	0	0	0
19. Profes	0	0	41,259	41,259	0	41,259	0	41,259
20. Fees,	0	0	8,688	8,688	0	8,688	-75	8,613
21. Clerica	88,899	4,876	25,941	119,716	0	119,716	-1,451	118,265
22. Emplo	0	0	390,742	390,742	0	390,742	0	390,742
23. Inserv	0	0	0	0	0	0	0	0
24. Travel	0	0	4,141	4,141	0	4,141	0	4,141
25. Other	0	0	2,317	2,317	0	2,317	0	2,317
26. Insura	0	0	49,901	49,901	0	49,901	0	49,901
27. Other	0	0	0	0	0	0	0	0
28. Total (	137,086	4,876	522,989	664,951	0	664,951	-1,526	663,425
29. Total (	1,806,429	274,833	648,264	2,729,526	0	2,729,526	-5,988	2,723,538
30. Depre	0	0	98,817	98,817	0	98,817	-2,357	96,460
31. Amorti	0	0	0	0	0	0	0	0
32. Interes	0	0	15,567	15,567	0	15,567	-10,037	5,530
33. Real E	0	0	170	170	0	170	-170	0
34. Rent -	0	0	0	0	0	0	0	0
35. Rent -	0	0	1,199	1,199	0	1,199	0	1,199
36. Other	0	0	0	0	0	0	0	0
37. Total (	0	0	115,753	115,753	0	115,753	-12,564	103,189
38. Medica	0	0	0	0	0	0	0	0
39. Ancilla	0	17,576	2,904	20,480	0	20,480	0	20,480
40. Barber	0	0	14,607	14,607	0	14,607	0	14,607
41. Coffee	0	0	0	0	0	0	0	0
42. Provid	0	0	52,560	52,560	0	52,560	0	52,560
43. Other	107,523	37,984	249,955	395,462	0	395,462	-395,462	0
44. Total S	107,523	55,560	320,026	483,109	0	483,109	-395,462	87,647
45. Grand	1,913,952	330,393	1,084,043	3,328,388	0	3,328,388	-414,014	2,914,374

	Operating	After Consolidation
General Service Cost Center		
1. Cash on hand and in banks	760,791	760,791
2. Cash - Patient Deposits	0	0
3. Accounts & Notes Recievable	401,508	401,508
4. Supply Inventory	0	0
5. Short-Term Investments	0	0
6. Prepaid Insurance	34,125	34,125
7. Other Prepaid Expenses	18,269	18,269
8. Accounts Receivable-Owner/Related Party	0	0
9. Other (specify):	0	0
10. Total current assets	1,214,696	1,214,696
LONG TERM ASSETS		
11. Long-Term Notes Receivable	0	0
12. Long-Term Investments	0	0
13. Land	63,710	63,900
14. Buildings, at Historical Cost	1,641,149	1,701,393
15. Leasehold Improvements, Historical Cost	0	0
16. Equipment, at Historical Cost	559,035	569,206
17. Accumulated Depreciation (book methods)	-1,567,631	-1,604,462
18. Deferred Charges	0	0
19. Organization & Pre-Operating Costs	0	0
20. Accum Amort - Org/Pre-Op Costs	0	0
21. Restricted Funds	0	0
22. Other Long-Term Assets (specify):	7,360	7,360
23. other (specify):	1,312,070	1,240,002
24. Total Long-Term Assets	2,015,693	1,977,399
25. Total Assets	3,230,389	3,192,095
CURRENT LIABILITIES		
26. Accounts Payable	47,650	47,650
27. Officer's Accounts Payable	0	0
28. Accounts Payable-Patients Deposits	3,854	3,854
29. Short-Term Notes Payable	55,000	55,000
30. Accrued Salaries Payable	153,354	153,354
31. Accrued Taxes Payable	2,958	2,958
32. Accrued Real Estate Taxes	0	0
33. Accrued Interest Payable	2,915	2,915
34. Deferred Compensation	0	0
35. Federal and State Income Taxes	0	0
36. Other Current Liabilities (specify):	2,129	2,129
37. Other Current Liabilities (specify):	0	0
38. Total Current Liabilities	267,860	267,860
LONG TERM LIABILITES		
39.Long-Term Notes Payable	944,080	944,080
40.Mortgage Payable	0	0
41.Bonds Payable	0	0
42.Deferred Compensation	0	0
43.Other Long-Term Liabilities (specify):	85,160	85,160
44.Other Long-Term Liabilities (specify):	0	0
45.Total Long-Term Liabilities	1,029,240	1,029,240
46.Total Liabilities	1,297,100	1,297,100
47.Total Equity	1,933,289	1,894,995
48.Total Liabilities and Equity	3,230,389	3,192,095

	Balance per Medicaid Trial Balance
1. Gross Revenue - All levels of Care	2,531,126
2. Discounts and Allowances for all Levels	99,540
Subtotal - Inpatient Care	2,630,666
4. Day Care	0
5. Other Care for Outpatients	0
6. Therapy	149,070
7. Oxygen	0
Subtotal - Anciliary Revenue	149,070
9. Payments for Education	0
10. Other Governmental Grants	0
11. Nurses Aide Training Reimbursements	
12. Gift and Coffee Shop	0
13. Barber and Beauty Care	14,108
14. Non-Patient Meals	8,006
15. Telephone, Television, and Radio	0
16. Rental of Facility Space	0
17. Sale of Drugs	26,537
18. Sale of Supplies to Non-Patients	0
19. Laboratory	19,059
20. Radiologyand X-Ray	0
21. Other Medical Services	67,063
22. Laundry	0
Subtotal - Other Operating Revenue	134,773
24. Contributions	737,004
25. Interest and Other Investments Income	15,961
Subtotal - Non-Operating Revenue	752,965
27. Other Revenue (specify):	358,672
28. Other Revenue (specify):	1,636
Subtotal - Other Revenue	360,308
30. Total Revenue	4,027,782
31. General Services	721,513
32. Health Care	1,310,944
33. General Administration	559,833
34. Ownership	118,970
35. Special Cost Centers	100,807
35. Provider Participation Fee	52,704
37. Other	0
40. Total Expenses	2,864,771
41. Income Before Income Taxes	1,163,011
42. Income Taxes	0
43. Net Income or Loss for the Year	1,163,011

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10 Attachment of Real Estate Bill and fill out form

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12 P12 does not show totals, it carries to P12a, therefore P12a must always be attached
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19 The bottom right side of page under **, you must write in any comments
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RECONCILIATION REPORT **Lutheran Care Center** **03:19 PM** **11/07/05**

ITEM	Value 1	Cond.	Value 2	Difference	RESULTS	COMPARE CEL	SUB-SCHED.	LINE NO.	COL. NO.	WITH CELL	SUB-SCHED.	LINE NO.	COL. NO.
Adjustment Detail	-414,014	equal to	-414,014	0	O.K.	Pg5 Z22	B.	37	1	Pg4 K29	N/A	45	7
Interest Expense	5,530	equal to	5,530	0	O.K.	Pg9 P34	A.	15	10	Pg4 L13	N/A	32	8
Real Estate Tax Expenses	0	equal to	0	0	O.K.	Pg10 W24	B.	5	N/A	Pg4 L14	N/A	33	8
Amortization exp. Pre-opening & org.	N/A	equal to	0	#VALUE!	#VALUE!	Pg11 I33	E.	3	N/A	Pg4 L12	N/A	31	8
Ownership Costs-Depreciation	96,460	equal to	96,460	0	O.K.	Pg13 Y28	E.	49	2	Pg4 L11	N/A	30	8
Rental Costs A	0	equal to	0	0	O.K.	Pg14 L20+N22	A.	7 + 8	4+N/A	Pg4 L15	N/A	34	8
Rental Costs B	1,199	equal to	1,199	0	O.K.	Pg14 J30+N40	B.+ C.	16+21	N/A+4	Pg4 L16	N/A	35	8
Nurse Aid Training Prog.	0	equal to	0	0	O.K.	Pg15 L36	B.	10	1	Pg3 L23	N/A	13	8
Special Serv.- Staff Wages	118,965	equal to		0	O.K.	Pg16 N32	N/A	14	3	Pg4 E22	N/A	39	1
Therapy Services	127,137	equal to	127,137	0	O.K.	Pg16 Z12+Z14...	N/A;B	1-4;40-43	8;2	Pg3 H20	N/A	1Oa	4
Special Serv.- Supplies	17,814	equal to	17,814	0	O.K.	Pg16 V32	N/A	14	6	Pg4 F22 + Pg 3	N/A	39,10a	2
Income Stat. General Serv.	719,337	equal to	719,337	0	O.K.	Pg19 P11	N/A	31	2	Pg3 H16	N/A	8	4
Income Stat. Health Care	1,345,238	equal to	1,345,238	0	O.K.	Pg19 P12	N/A	32	2	Pg3 H26	N/A	16	4
Income Stat. Admininstation	664,951	equal to	664,951	0	O.K.	Pg19 P13	N/A	33	2	Pg3 H39	N/A	28	4
Income Stat. Ownership	115,753	equal to	115,753	0	O.K.	Pg19 P15	N/A	34	2	Pg4 H18	N/A	37	4
Income Stat. Special Cost Ctr	430,549	equal to	430,549	0	O.K.	Pg19 P17	N/A	35	2	Pg4 H21..H24+H	N/A	38to41+43	4
Income Stat. Prov. Partic.	52,560	equal to	52,560	0	O.K.	Pg19 P18	N/A	36	2	Pg4 H25	N/A	42	4
Staff- Nursing	982,951	equal to	1,059,967	-77,016	FAILED	Pg20 K11..K15+	A.	1-5,24,25,27-30	3	Pg3 E19	N/A	10	1
Staff- Nurse aide Training	0	< or = to		0	O.K.	Pg20 K16	A.	6	3	Pg3 E23	N/A	13	1
Staff-Licensed Therapist	83,987	equal to		0	O.K.	Pg20 K17	A.	7	3	Pg4 E22	N/A	39	1
Staff- Activities	39,808	equal to	39,808	0	O.K.	Pg20 K19+K20	A.	9+10	3	Pg3 E21	N/A	11	1
Staff- Social Serv. Workers	39,689	equal to	39,689	0	O.K.	Pg20 K21	A.	11	3	Pg3 E22	N/A	12	1
Staff- Dietary	228,182	equal to	228,182	0	O.K.	Pg20 K22..K26	A.	16-Dec	3	Pg3 E9	N/A	1	1
Staff- Maintenance	31,294	equal to	31,294	0	O.K.	Pg20 K27	A.	17	3	Pg3 E14	N/A	6	1
Staff- Housekeeping	83,053	equal to	83,053	0	O.K.	Pg20 K28	A.	18	3	Pg3 E11	N/A	3	1
Staff- Laundry	68,385	equal to	68,385	0	O.K.	Pg20 K29	A.	19	3	Pg3 E12	N/A	4	1
Staff- Administrative	48,187	equal to	48,187	0	O.K.	Pg20 K30..K32	A.	20-22	3	Pg3 E28	N/A	17	1
Staff- Clerical	88,899	equal to	88,899	0	O.K.	Pg20 K33..K34	A.	23+24	3	Pg3 E32	N/A	21	1
Staff- Medical Director	0	equal to		0	O.K.	Pg20 K37	A.	27	3	Pg3 E18	N/A	9	1
Total Salaries And Wages	1,913,952	equal to	1,913,952	0	O.K.	Pg20 K44	A.	34	3	Pg4 E29	N/A	45	1
Dietary Consultant	5,471	< or = to	6,671	-1,200	O.K.	Pg20 X12	B.	35	2	Pg3 G9	N/A	1	3
Medical Director	400	< or = to	400	0	O.K.	Pg20 X13	B.	36	2	Pg3 G18	N/A	9	3
Consultants & contractors	2,289	< or = to	2,588	-299	O.K.	Pg20 X14..X16+	B. & C.	37to39 and 50to5	2	Pg3 G19	N/A	10	3
Activity Consultant	537	< or = to	2,390	-1,853	O.K.	Pg20 X21	B.	44	2	Pg3 G21	N/A	11	3
Social Service Consultant	537	< or = to	537	0	O.K.	Pg20 X22	B.	45	2	Pg3 G22	N/A	12	3
Supp. Sched.- Admin. Salar.	48,187	equal to	48,187	0	O.K.	Pg21 I16	A.	N/A	N/A	Pg3 E28	N/A	17	1
Supp. Sched.- Admin. Other		equal to		0	O.K.	Pg21 I24	B.	N/A	N/A	Pg3 G28	N/A	17	3
Supp. Sched.- Prof. Serv.	41,259	equal to	41,259	0	O.K.	Pg21 I41	C.	N/A	N/A	Pg3 G30	N/A	19	3
Supp. Sched.- Benefit/Taxes	390,742	equal to	390,742	0	O.K.	Pg21 P22	D.	N/A	N/A	Pg3 L33	N/A	22	8
Supp. Sched.- Sched of dues..	8,613	equal to	8,613	0	O.K.	Pg21 V22	F.	N/A	N/A	Pg3 L31	N/A	20	8
Supp. Sched.- Sched. of trav	4,141	equal to	4,141	0	O.K.	Pg21 V41	G.	N/A	N/A	Pg3 L35	N/A	24	8
Gen. Info - Particip. Fees	52,560	equal to	52,560	0	O.K.	Pg23 I38	N/A	11	N/A	Pg4 G25	N/A	42	3
Gen. Info - Employee Meals	0	< or = to		0	O.K.	Pg23 S16	N/A	16	N/A	Pg3 K33	N/A	2 & 22	7
Gen. Info - Employee Meals	0	equal to	0	0	O.K.	Pg23 S16	N/A	16	N/A	Pg21 P12	D.	N/A	N/A
Nurse aide training	0	equal to		0	O.K.	Pg15 U29..U31	B.	3, 4 & 5	4	Pg3 E23	N/A	13	1
Days of medicare provided	1,115	equal to	1,115	0	O.K.	Pg2 AB29	K.	N/A	N/A	Pg2 J30	B.	8	4
Adjustment for related org. costs		equal to	0	#VALUE!	#VALUE!	Pg5 Z18	B.	34	1	Pg6 to Pg 6I Y4(	B.	14	8
Total loan balance	999,080	equal to	999,080	0	FAILED	Pg9 L34	A.	15	7	Pg17 V13+V27..	N/A	29+39-41	2
Real estate tax accrual	0	equal to		0	O.K.	Pg10 W15	B.	4	N/A	Pg17 V17	N/A	32	2
Land	63,900	equal to	63,900	0	O.K.	Pg11 T43	A.	3	4	Pg17 K25	N/A	13	2
Building cost	1,701,393	equal to	1,701,393	0	O.K.	Pg12 to 12I L43	B.	36	4	Pg17 K26+K27	N/A	14 & 15	2
Equipment and vehicle cost	569,206	equal to	569,206	0	O.K.	Pg13 O22+L13	C.& D.	41 + 46	1 + 4	Pg17 K28	N/A	16	2
Accumulated depr.	1,604,462	equal to	1,604,462	0	O.K.	Pg13 Y30	E.	51	2	Pg17 K29	N/A	17	2
End of year equity	1,933,286	equal to	1,933,286	0	O.K.	Pg18 I33	N/A	24	1	Pg17 S39	N/A	47	1
Net income (loss)	699,394	equal to	699,394	0	O.K.	Pg18 I15	N/A	7	1	Pg19 P30	N/A	43	2
Unamortized deferred maint. cost	0	equal to		0	O.K.	Pg22 F31-J31..S	H.	20	3	Pg17 K30	N/A	18	2
Balance Sheet	3,230,386	equal to	3,230,386	0	O.K.	Pg17:H41		25	1	Pg17 S41	N/A	48	1